DEFINITION OF AN HMO THAT IS NOT FEDERALLY QUALIFIED

Any health maintenance organization (HMO) with which the Department enters into a contract* must meet at least the following requirements:

1. Be organized primarily for the purpose of providing health care services.

2. Make the services it provides to its Medicaid enrollees as accessible (as defined at IAC 498 88.7 (249A)) to them (in terms of timeliness, amount, duration and scope) as those services are to non-enrolled Medicaid recipients within the area served by the HMO.

3. Make provisions satisfactory to the Department against the risk of insolvency and assure that Medicaid enrollees will not be liable for the HMO's debts if it does become insolvent. Compliance with this factor exists with the Iowa Administrative Rules in effect through the Department of Commerce, Insurance Division. These rules include deposit requirements at 510-40.12 (514B) and reporting requirements at 510-40.14 (514B).

4. Be licensed and approved by the State of Iowa through the Administrative Rules at 510-Chapter 40.

5. Abide by confidentiality guidelines at IAC 498-88.9(3).

6. Maintain a medical records system as described at IAC 498-88.9 (249A).

7. Ensure Quality Assurance standards as identified at IAC 498-88.13 (249A).

8. Provide a grievance procedure which is approved by the Department (IAC 88.8 (249A)).

9. Agree to Departmental approval of marketing procedures found at IAC 498-88.10 (249A).

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* The contract must meet these minimum requirements:

1. Be in writing.
2. Shall be for services covered.
3. Renewable by mutual consent for a period of up to three years.
4. Specify enrollment area.
5. List conditions for non renewal, termination (see IAC 498 88.2(3)), suspension, and modification.
6. Specify method and rate of reimbursement (IAC 498-88.12 (249A))
7. Provide for disclosure of ownership and subcontractor relationship.
8. Will be made with the licensee by the Department.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: IOWA

MEDICAL MANAGED HEALTH CARE (MHC)
MediPASS (PCCM) and MCO Options

Citation: Section 1932 of the Social Security Act

A. General Description of the Program

1. This program is called Medical Managed Health Care (MHC). All Medicaid beneficiaries as described in Section C are required to enroll in either a managed care organization (MCO), also known as a health maintenance organization (HMO), or into the MediPASS program, a primary care case management (PCCM) program. Those described in Section D are not subject to mandatory enrollment.

2. The objectives of this program are to reduce costs, reduce inappropriate utilization, and ensure adequate access to care for Medicaid recipients.

3. This program is intended to enroll Medicaid recipients in MCOs, which will provide or authorize all primary care services and all necessary specialty services, or into the MediPASS program, where the assigned medical practitioner will authorize all primary care services and all necessary specialty services. The MCO or the MediPASS assigned practitioner will act as the patient manager (PM). The PM is responsible for monitoring the care and utilization of non-emergency services. Neither emergency nor family planning services are restricted under this program.

4. The PM will assist the participant in gaining access to the health care system and will monitor the participant's condition, health care needs, and service delivery on an ongoing basis. The PM will be responsible for locating, coordinating, and monitoring all primary care and other covered medical and rehabilitation services on behalf of recipients enrolled in the program.

5. Recipients enrolled under this program will be restricted to receive covered services from the PM or upon referral and authorization of the PM. The Patient Manager will manage the recipient's health care delivery. The MHC program is intended to enhance existing provider-patient relationships and to establish a relationship where there has been none. It will enhance continuity of care and efficient and effective service delivery. This is accomplished by providing the recipient with a choice between at least two MediPASS PMs or a combination of one MCO and the MediPASS program. Recipients will have a minimum of 10 days to make the selection but may change the initial selection at any time within the first 90 days of enrollment and at least every 12 months thereafter (without cause). The enrollment broker facilitates this through enrollment counseling and information distribution so recipients may make an informed decision. (See Section E for more details.)

6. Non-MCO contractors will act as enrollment brokers in assisting eligible recipients in choosing among competing health plans in order to provide recipients with more information about the range of health care options open to them.

7. The state will share cost savings with recipients resulting from the use of more cost-effective medical care with recipients by eliminating co-payments for those who enroll into an MCO program. Co-payments will apply for those services provided under the MediPASS program.

8. The state requires recipients in MediPASS to obtain services only from Medicaid-participating providers who provide such services. Providers must meet reimbursement, quality, and utilization standards that are consistent with access, quality, and efficient and economic provisions of covered care and services. Recipients enrolled in MCO plans may be referred to any MCO-credentialed provider. The plan may also choose to allow non-emergency care to be provided by other practitioners on a case-by-case basis if it benefits the enrollee.

9. MediPASS will operate in all counties of the state except in those geographical areas without an adequate number of primary care case managers participating in MediPASS. The MCO program will operate in counties where MCOs have contracted with the state. Mandatory assignment will only occur if the recipient has a choice between at least two MediPASS PMs or a combination of one MCO and the MediPASS program.

B. Assurances and Compliance

1. Consistent with this description, the state assures that all the requirements of Sections 1932, 1903(m), and 1905(t) of the Social Security Act will be met.

2. The MHC program is available in selected counties in Iowa. Mandatory enrollment provisions will not be implemented unless a choice of at least two MediPASS PMs or a combination of MCO and the MediPASS program is available.

3. Iowa has safeguards in effect to guard against conflict of interest on the part of employees of the state and its agents.

4. Iowa will monitor and oversee the operation of the mandatory managed care program, ensuring compliance with all federal program requirements, federal and state laws and regulations, and the requirements of the contracts agreed upon by Medicaid and its contractors.

5. Iowa will evaluate compliance by review and analysis of reports prepared and sent to the Iowa Medicaid agency by the contractors. Deficiencies in one or more areas will result in the contractor being required to prepare a corrective action plan, which will be monitored by the Iowa Medicaid agency.

6. Reports from the grievance and complaint process will be analyzed and used for evaluation purposes.

7. Iowa staff will provide technical assistance as necessary to ensure that contractors have adequate information and resources to comply with all requirements of law and their contracts.

8. Iowa staff will evaluate each contractor for financial viability/solvency, access and quality assurance.

C. Target Groups of Recipients

The MHC program is limited to the following target groups of recipients:

1. Families, children, and pregnant women eligible for Medicaid under Section 1931 of the Social Security Act or related coverage groups.

2. Recipients eligible for Medicaid through the Medicaid expansion under the State Child Health Insurance Program (SCHIP). (Recipients in the Iowa's separate SCHIP program are not enrolled in managed health care.)

D. Mandatory Enrollment Exclusions

1. The following groups will not be enrolled in managed care:

   a. Dual Medicare – Medicaid eligibles.

   b. Recipients enrolled in the Medically Needy program.

   c. American Indians who are members of federally recognized tribes. Iowa's eligibility system (the Automated Benefit Calculation system) contains a field for ethnicity which caseworkers use to document whether a person applying for benefits is a member of a federally recognized tribe. This already existing indicator will be used to exempt American Indians from the mandatory enrollment process in Medicaid managed care.

      Currently, the Mesquaki Tribe is the only Federally recognized American Indian Tribe in Iowa. It is a subset of the Sac and Fox of the Mississippi. The Iowa Tribe has 1,277 enrolled members. The improving economic conditions on the Mesquaki Settlement, primarily due to casino revenue, have resulted in a significant growth trend and a 200% birth rate increase since 1992. The Automated Benefit Calculation system will identify any Mesquaki members (as well as members of other tribes) who participate in Medicaid.

d. Children under 19 years of age who are any of the following:

(1) Eligible for SSI under Title XIX.

(2) Described in Section 1902(e)(3) of the Social Security Act.

(3) In foster care or other out-of-home placement.

(4) Receiving foster care or adoption assistance.

(5) Receiving services through a family centered, community–based coordinated care system receiving grant funds under Section 501(a)(1)(D) of Title V. Recipients that are not excluded from enrollment under this subsection are defined as children with special health-care needs that are receiving direct financial assistance from the State's Maternal and Child Health Care program.

After consultation with the State's Maternal and Child Health agency, an agreement was made that these recipients will be identified using appropriate medical status codes from the Medicaid Management Information System and through a data file transfer undertaken monthly between the Title V Agency and the Department of Human Services. Any additional recipients that would be affected by this subsection will be requested to identify themselves in the enrollment process.

If Iowa's Maternal and Child Health Care program identifies any child for whom they are providing comprehensive services in that program who is enrolled in MHC, arrangements will be made to immediately disenroll the child from MHC with the appropriate exclusion code. Services provided to such children will not require authorization. Providers will be given emergency authorizations for claims processing until the child can be disenrolled.

e. Recipients who are residing in a nursing facility or ICF/MR.

f. Recipients who have an eligibility period that is only retroactive.

g. Recipients who participate in a home and community-based waiver.

h. Recipients who are older than 65 years of age.

i. Recipients who have commercial insurance paid under the Health Insurance Payment Program.

j. Recipients placed into the "lock-in" program by the Department after consultation with the Iowa Foundation for Medical Care.

E. Enrollment and Disenrollment

1. All recipients will be given the opportunity to choose from at least two MHC providers including enrollment into an MCO where this option is available. If a recipient has a prior provider relationship that they wish to maintain, the enrollment broker will assist the recipient in choosing a managed care entity that will maintain this relationship.

Iowa contracts with an independent contractor to conduct the enrollment process and related activities. The enrollment broker performs services and supplies information as follows to facilitate the enrollment process:

a. Under direction and oversight by the Department, recruit MediPASS patient managers for the PCCM model of the program.

b. Review provider access for each county quarterly to assure appropriate primary care access for the enrollees.

c. Answer MHC-related questions from recipients and providers.

d. Prepare enrollment materials for MHC program, for Department approval, and store all MHC materials (MCO, MediPASS and MHC in general).

e. Process new enrollment packets for those MHC eligibles identified by the Department.

f. Process the recipient's choice of MHC option and send enrollments to the Department for inclusion on the next monthly medical card.

g. Log all grievances and requests for special authorization from MediPASS enrollees.

h. Review recipient's request for enrollment change during EPP for good cause.

i. Perform various quality assurance activities for the MHC program. This includes but is not limited to; paid claim audits, 24-hour access audit, appointment system survey, encounter data validation, review and approval of special authorization for MediPASS enrollees, recipient and provider educational correspondence, and utilization review for MediPASS providers.

j. Supplies an enrollment packet to the recipient that includes individual MCOs' informing materials and information supplied by the state.

k. Provides enrollment counseling which includes:

(1) Inquiring about patient/provider experience and preference.

(2) Providing information on which MCOs or MediPASS PMs are available to maintain a prior patient-provider relationship.

(3) Facilitating direct contact with individual MCOs, as necessary.

(4) Providing any information and education concerning the enrollment process, individual MCOs', benefits offered, the enrollment packet, and any of the other information provided for in this section.

l. If the recipient fails to choose an MCO or MediPASS PCCM provider within a minimum of 10 calendar days after receiving enrollment materials, the Department assigns the recipient to a PCCM or MCO.

m. Iowa allows MCOs/PHPs or primary care case managers to assist in enrolling beneficiaries. There are times when the MCO or the MediPASS provider's office might be the initial point of contact with the MHC recipient. In order to process the recipient's enrollment choice efficiently, the Department does allow for the enrollment choice to be communicated to the enrollment broker from the MCO or the MediPASS provider's office. However, there are some safeguards in place to ensure that the correct enrollment is processed and that the choice is truly from the recipient.

The MCOs' and MediPASS providers' offices are able to have a supply of MHC enrollment forms at their location. The enrollment form does require the signature of the case name (Medicaid applicant) in order to be accepted and processed by the enrollment broker. Telephone calls from either place will require that the person listed as the case name be on the phone making the enrollment choice.

2. Default enrollment will be based upon maintaining prior provider-patient relationships or, where this is not possible, on maintaining an equitable distribution among managed care entities.

3. Information in an easily understood format will be provided to beneficiaries on providers, enrollee rights and responsibilities, grievance and appeal procedures, covered items and services, benefits not covered under the managed care arrangement, and comparative information among managed care entities regarding benefits and cost sharing, service areas, and quality and performance (to the extent available).

4. Any selection or assignment of an MCO or PCCM may be changed at the request of the recipient for the following "good cause" reasons: poor quality of care, lack of access to special services or other reasons satisfactory to the Department. Some examples of these reasons would be if a new MHC option becomes available in the enrollees' county, or if a provider within a network were to leave and that provider's patients/enrollees wish to change options to continue the same doctor/patient relationship. Whenever an enrollee is receiving prenatal care, there is a 'good cause' reason for allowing the enrollee to change options to maintain the existing doctor/patient relationship. Recipients may disenroll at any time for good cause.

5. During the first 90 days of the initial enrollment and the first 90 days of enrollment each nine months after the date of the initial enrollment, the recipient can change from one MCO or PCCM to another without cause.

6. Enrollees will be provided notification 60 days before the end of a lock-in period of their opportunity to make a new choice of MCO or PCCM.

7. Enrollees will be given an opportunity to change MCOs or PCCMs and will be sent a notice to that effect.

8. MCOs and PCCMs will not discriminate against individuals eligible to be covered under the contract on the basis of health status or need of services.

9. The MCO and PCCMs will not terminate enrollment because of an adverse change in the recipient's health.

10. An enrollee who is terminated from an MCO or PCCM solely because the enrollee has lost Medicaid eligibility for a period of two months or less will automatically be re-enrolled into the same MCO or PCCM upon regaining eligibility.

11. As stated in Section E.5, an enrollment period shall not exceed nine months. An enrollee may disenroll following the initial 90 days of any period of enrollment if all of the following circumstances occur:

    a. The enrollee submits a request for disenrollment to the Department citing good cause for disenrollment.

    b. The request cites the reason or reasons why the recipient wishes to disenroll.

    c. The Department determines good cause for disenrollment exists.

12. The recipient will be informed at the time of enrollment of the right to disenroll.

13. An enrollee will be allowed to choose his or her health professional in the MCO to the extent possible and appropriate and will be allowed to change his or her health professional as often as requested per the policy of the MCO. Changes made for good cause are not considered as a request for change if the MCO sets a number of changes allowed yearly.

14. Enrollees will have access to specialists to the extent possible and appropriate and female enrollees will have direct access to women's health services.

F. Process for Enrollment in an MCO/PCCM

The following process is in effect for recipient enrollment in the MHC Program:

1. The Department shall provide beneficiaries with information in an easily understood format on providers, enrollee rights and responsibilities, grievance and appeal procedures, covered items and services, benefits not covered under the managed care arrangement, and comparative information among MCEs regarding benefits and cost sharing, service areas, and quality and performance (to the extent available).

2. All materials will be in an easily understood format (6th grade reading level or less). Materials will be translated into languages other than English if 10% of the population or 1,000 people in a service area speak a language other than English as their primary language.

3. Recipients will be able to select an MCO or PCCM from a list of available managed care entities in their county as well as those in contiguous counties. If the recipient wishes to remain with a primary care case manager or MCO with whom a patient/physician relationship is already established, the recipient is allowed to do so. Each recipient shall notify the Department by mail, telephone or in person, of his or her choice of plans. If voluntary selection is not made within the 10-calendar day period describe above, the Medicaid program shall assign an MCO or PCCM in accordance with the procedures outlined in E above.

4. As indicated in Section E, if the recipient does not choose a PM , the Department will assign the recipient to a PM and notify the recipient of the assignment.

5. The MCO and PCCM will be informed electronically of the recipient's enrollment in that MCO.

6. The recipient will be notified of enrollment and issued an identification card.

7. Additionally, each MCO will provide recipients the following information within ten days after notice of enrollment:

   a. Benefits offered, the amount, duration, and scope of benefits and services available.

   b. Procedures for obtaining services.

   c. Names and locations of current network providers, including providers that are not accepting new patients.

   d. Any restrictions on freedom of choice.

   e. The extent to which there are any restrictions concerning out-of-network providers.

   f. Policies for specialty care and services not furnished by the primary care providers.

   g. Grievance and appeal process.

   h. Member rights and responsibilities.

G. Maximum Payments

Section 1902(a)(30) of the Act and implementing regulations prohibit payments to an MCO contractor from exceeding the cost to the agency of providing these same services on a fee-for-service basis to an actuarially equivalent nonenrolled population. Iowa fee-for-service costs are considered in the development of the upper payment limit and the managed care rates. The contract with the actuary requires that calculated rates shall be actuarially sound and consistent with the upper payment limit requirement at 42 CFR 447.361. State payments to contractors will comply with the upper payment limit provisions in 42 CFR 447.361.

H. Covered Services

1. Services not covered by the MHC program will be provided under the Medicaid fee-for-service program. Medicaid recipients will be informed of the services not covered under the MHC Program, the process for obtaining such services. The State assures that the services provided within the managed care network and out-of plan and excluded services will be coordinated. The required coordination is specified in the state contract with MCOs and PCCMs and is specific to the service type and service provider.

2. MCOs are encouraged to develop subcontracts or memoranda of understanding with federally qualified health centers (FQHCs) and rural health clinics (RHCs) as well as family planning clinics.

3. Preauthorization of emergency services and emergency post stabilization services and family planning services by the recipient's MCO is prohibited. Recipients will be informed that emergency and family planning services are not restricted under the MHC Program. "Emergency services" are defined in the MCO contract and Iowa Administrative Code 441--88.

4. The PCCM shall be responsible for managing the services marked below in column (7). The MCO capitated contract will contain the services marked below in Column (4). All Medicaid-covered services not marked in those columns will be provided by the Iowa Plan (under the requirements of that program) or Medicaid fee for service (without referral). Mental health and substance abuse treatment services are provided under the Iowa Plan for Behavioral Health under the current 1915(b) waiver in effect for those services.

Service (1)	State Plan Approved (2)	1915(b)(3) Waiver Services (3)	MCO/PHP Capitated Reimbursement (4)	Fee-for-Service Reimbursement Impacted by MCO/PHP (5)	Fee-for-Service Reimbursement for MCO/PHP (6)	PCCM Referral/ Prior Auth. Required (7)	Wraparound Service Impacted by PCCM (8)	PCCM Referral/Prior Authorization Not Required or Non-Waiver Services (9)
Day Treatment Services	X		X			X		
Dental	X				X			X
Detoxification	X		X					?
Durable Medical Equipment	X		X			X		
Education Agency Services	X				X			X
Emergency Services	X		X					X
EPSDT	X		X					X
~~Family Planning~~ Services	X				X			X
Federally Qualified Health Center Services	X		X			X		
Home Health	X		X			X		
Hospice	X		X			X		

Service (1)	State Plan Approved (2)	1915(b)(3) Waiver Services (3)	MCO/PHP Capitated Reimburse ment (4)	Fee-for-Service Reimburse-ment Impacted by MCO/PHP (5)	Fee-for-Service Reimburse-ment for MCO/PHP (6)	PCCM Referral/ Prior Auth. Required (7)	Wraparound Service Impacted by PCCM (8)	PCCM Referral/Prior Authorization Not Required or Non-Waiver Services (9)
Inpatient Hospital – Psych	X				X			X
Inpatient Hospital – Other	X		X			X		
Immunizations	X		X					X
Lab and X-ray	X		X			X		
Nurse Midwife	X		X			X		
Nurse Practitioner	X		X			X		
Nursing Facility	X				X			X
Obstetrical Services	X		X			X		
Occupational Therapy	X		X			X		
Other Fee-for-Service Services	X		X			X		
Other Psych. Practitioner	X				X			X
Outpatient Hospital – All Other	X		X			X		
Outpatient Hospital – Lab & X-ray	X		X			X		
Partial Hospitalization	X		X			X		
Pharmacy	X				X			X
Physical Therapy	X		X			X		
Physician	X		X			X		
Prof. & Clinic and Other Lab and X-ray	X		X			X		
Psychologist	X				X			X

Service (1)	State Plan Approved (2)	1915(b)(3) Waiver Services (3)	MCO/PHP Capitated Reimbursement (4)	Fee-for-Service Reimbursement Impacted by MCO/PHP (5)	Fee-for-Service Reimbursement for MCO/PHP (6)	PCCM Referral/ Prior Auth. Required (7)	Wraparound Service Impacted by PCCM (8)	PCCM Referral/Prior Authorization Not Required or Non-Waiver Services (9)
Rehabilitation Treatment Services	X				X			X
Respiratory Care	X		X			X		
Rural Health Clinic	X		X			X		
Speech Therapy	X		X			X		
Substance Abuse Treatment	X				X			X
Testing for Sexually Transmitted Diseases	X		X			X		
Transportation – Emergency	X		X			X		
Transportation - Non-emergency	?		?			?		
Vision Exams and Glasses	X			X				X

I. Mandates

1. In the MCO program, Iowa will enter into contracts with State licensed MCOs. Iowa will enter into comprehensive risk contracts with the MCOs. These organizations will arrange for comprehensive services, including inpatient or outpatient hospital, laboratory, x-ray, physician, home health, early periodic screening, diagnosis and treatment, family planning services and all other Medicaid optional services, except for those described in Section H.1.

   All contracts will comply with Sections 1932 and 1903(m) of the Act. All contracts Iowa has selected the MCOs that operate under the MHC program in the following manner: Iowa has used and will use an open cooperative procurement process, in which any qualifying MCO/PHP that complies with federal procurement requirements and 45 CFR Section 74 may participate. The Department requires all participating MCOs to be licensed by the Iowa Department of Commerce, Insurance Division. This licensure also identifies the MCO service area, by county in the state. The Department sets the capitation rates by region in the state and any participating MCO must accept those rates for the respective Medicaid covered services.

2. With respect to MediPASS, the contracts Iowa enters into with PMs will contain (at a minimum) all terms required under section 1905(t)(3). Reimbursement will be made on a fee-for-service basis, with a $2.00 monthly case management fee for each MediPASS recipient assigned. The following is a list of the types of providers that qualify to be primary care providers under the MHC program: physicians (pediatricians, family practitioners, internists, general practitioners, obstetrician/gynecologists), FQHCs, RHCs).

   Certified nurse practitioners are not included as a PCCM type; however these services will be made available: The Department covers these services in the same manner as fee-for-service. The only difference is that a referral from the MediPASS provider is required for reimbursement of the services. Any Iowa Medicaid provider of this type is able to see and treat a MediPASS recipient with the required referral.

   Nurse midwives are not included as a PCCM type, however these services will be made available: The Department covers these services in the same manner as under fee for service. The only difference is that a referral from the MediPASS provider is required for reimbursement of the services. Any Iowa Medicaid provider of this type is able to see and treat a MediPASS recipient with the required referral.

3. All participating primary care case managers shall be required to sign a MediPASS participation agreement in addition to the standard Medicaid provider agreement and shall be bound by its terms and conditions. Each PCCM shall be required to specify the number of recipients the PCCM is willing to serve as primary care case manager. Unless circumstances exist which require the Department to authorize a higher quota for a PCCM to ensure adequate coverage in an area, the maximum shall be 1,500 recipients per primary care case manager. In addition, the Department does increase the enrollment limit by 300 for MediPASS providers that have a physician assistant participating in the program. (See also Item M.12.)

4. Primary care case managers under the MHC program must:

   a. Be Medicaid-qualified providers and agree to comply with all applicable federal statutory and regulatory requirements, including those in Section 1932 of the Act and 42 CFR 434 (and new requirements in 42 CFR 438 when final) and all State plan standards regarding access to care and quality of service;

   b. Sign a contract or addendum for enrollment as a primary care case manager which explains the primary care case manager's responsibilities and complies with the PCCM contract requirements in Section 1905(t)(3) of the Act including: making available 24-hour, 7 days per week access by telephone to a live voice (an employee of the primary care case manager or an answering service) or an answering machine which will immediately page an on-call medical professional for information, referral, and treatment of medical emergencies; referrals for non-emergency services; or to information about accessing services or how to handle medical problems during non-office hours;

c. Provide comprehensive primary health care services to all eligible Medicaid beneficiaries who choose or are assigned to the primary care case manager's practice;

d. Refer or have arrangements for sufficient numbers of physicians and other appropriate health care professionals to ensure that services under the contract can be furnished to enrollees promptly and without compromise to quality of care;

e. Have hours of operations that are reasonable and adequate. The MediPASS provider must have the same hours of operation for the MHC enrollees as they have for their other patients. The Department requires all MediPASS providers to have 24-hour access via telephone. This does allow for another provider to be on-call for the MediPASS provider during non-office hours. The MediPASS provider must respond to a referral request phone call within 30 minutes;

f. Not refuse an assignment or disenroll an enrollee or otherwise discriminate against an enrollee solely on the basis of age, sex, race, physical or mental handicap, national origin, or health status or need for health services, except when that illness or condition can be better treated by another provider type;

g. Take beneficiaries in the order in which they enroll with the primary care case manager;

h. Not have an affiliation with person debarred, suspended, or otherwise excluded from federal procurement activities per Section 1932(d)(1) of the Act;

i. Restrict enrollment to people residing sufficiently near a service delivery site of the primary care case manager to be able to reach that site within a reasonable time using available and affordable modes of transportation;

5. Qualifications and requirements for PMs are noted in the provider agreements. MCOs and MediPASS PMs shall meet all of the following requirements:

a. An MCO shall be a Medicaid-qualified provider and agree to comply with all pertinent Medicaid regulations and state plan standards regarding access to care and quality of services.

b. The MCO shall sign a certification agreement that explains the responsibilities MCOs must comply with.

c. The MCO shall have a state-approved grievance and appeal process.

d. The MCO or MediPASS PM shall provide comprehensive primary health care services to all eligible Medicaid recipients who choose, or are assigned to, the MCO or MediPASS Program.

e. The MCO or MediPASS PM shall refer enrollees for specialty care, hospital care, or other services when medically necessary.

f. The MCO or MediPASS PM shall make available 24-hour, 7-day-a-week access by telephone to a live voice (an employee of the MCO or a representative or a representative of the MediPASS PM) or an answering machine which will immediately direct an enrollee as to how to contact an on-call medical professional, so that referrals can be made for non-emergency services and information can be given about accessing services or how to handle medical problems during non-office hours.

g. The MCO or MediPASS PM shall not refuse an assignment, disenroll a participant, or otherwise discriminate against a participant solely on the basis of age, sex, physical or mental disability, national origin, or type of illness or condition, except when that illness or condition can be better treated by another provider type.

h. The MCO or MediPASS PM shall request reassignment of the participant to another MCO or MediPASS PM only if the patient/provider relationship meets "good cause" reasons. The Department does allow MCOs and PCCMs to request that an enrollee be disenrolled or prohibited from enrolling for good cause. All reassignments must be state-approved. Good cause is defined as enrollment harmful to the enrollee or the MCO, excluding the enrollee's health or a change therein which may have an adverse financial effect on the MCO.

The Department reviews all 'good cause' reasons for transfer on a quarterly basis via the reports from the enrollment broker. The Department meets with the enrollment broker weekly to review all current issues, including any requests for disenrollment by any MediPASS provider or MCO.

i. All MCO subcontractors shall be required to meet the same requirements as those that are in effect for the contractor.

j. The MCO shall be licensed by the Division of Insurance in the Iowa Department of Commerce in order to ensure financial stability (solvency) and compliance with regulations.

k. Access to medically necessary emergency services shall not be restricted. "Emergency medical condition" means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in (i) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, (ii) serious impairment to bodily functions, or (iii) serious dysfunction of any bodily organ or part.

l. Iowa ensures enrollee access to emergency services by requiring the MCO/PHP/PCCM to provide adequate information to all enrollees regarding emergency service access.

m. Iowa ensures enrollee access to emergency services by including in the contract requirements for MCOs/PHPs/PCCMs to cover the following.

(1) The screening or evaluation and all medically necessary emergency services, when an enrollee is referred by the PCP or other plan representative to the emergency room, regardless of whether the prudent layperson definition was met,

(2) The screening or evaluation, when an absence of clinical emergency is determined, but the enrollee's presenting symptoms met the prudent layperson definition,

(3) Both the screening or evaluation and stabilization services, when a clinical emergency is determined,

(4) Continued emergency services until the enrollee can be safely discharged or transferred,

(5) Post-stabilization services that are pre-authorized by the MCO/PHP or primary care case manager, or were not pre-authorized, but the MCO/PHP or the primary care case manager failed to respond to request for pre-authorization within one hour, or could not be contacted. Post-stabilization services remain covered until the MCO/PHP or primary care case manager contacts the emergency room and takes responsibility for the enrollee.

J. Additional Requirements

1. Any marketing materials available for distribution under the Act and state statutes shall be provided to the Department for its review and approval.

2. The MCO shall certify that no recipient will be held liable for any MCO debt as the result of insolvency or for services Iowa Medicaid will not pay for.

3. The MCO shall include safeguards against fraud and abuse, as provided in state statutes.

4. The MCO shall allow the state to take sanctions as prescribed by federal or state statutes. Also, the MCO shall provide assurance that due process will be provided.

K. FQHC and RHC Services

The program is **mandatory** and the enrollee is guaranteed a choice of either an FQHC as a primary care case manager, a primary care manager that contracts with an FQHC, or at least one MCO/PHP which has at least one FQHC as a participating provider.

If the enrollee elects not to select a managed care choice that gives access to FQHC services, no FQHC services are required to be furnished to the enrollee while the enrollee is enrolled with the MCO/PHP/PCCM selected. In any event, since reasonable access to FQHC services will be available under the MHC program, FQHC services outside the program will not be available.

All of the FQHCs in the state are participating in the MediPASS program. This allows any recipient to be able to select the FQHC as the primary care case manager. In addition, the MCO contract specifically mentions the encouragement to contract with FQHCs in the service area. FQHC reimbursement will follow all applicable federal requirements. The MCOs must pay FQHCs and RHCs rates comparable to non-FQHC and RHC providers. Iowa pays prospective payments in accordance with the approved Iowa State Plan.

L. Quality of Health Care and Services, Including Access

1. Iowa requires all MCOs and providers, by contract, to meet state-specified standards for internal quality improvement programs (QIPs).

2. On a periodic or continuous basis, Iowa monitors the adherence to these standards by all MCOs, through the following mechanisms:

   a. Review of the written QIP for each MCO to monitor adherence to the Iowa QIP standards. Such review shall take place at least annually.

   b. Periodic review of numerical data or narrative reports describing clinical and related information on health services and outcomes of health care for the Medicaid enrolled population. This data will be submitted to the Department as required by the contract with the MCO.

   c. Monitoring of the implementation of the QIP to ensure compliance with Iowa QIP standards. This monitoring is conducted on-site at both the MCO administrative offices and the care delivery sites, as necessary. At least one such monitoring visits shall occur per year.

   d. Monitoring through the use of Department personnel and contracted staff.

3. The Department will arrange for an independent, external review of the quality of services delivered under each MCO's contract with the state. The review will be conducted for each MCO contractor on an annual basis. The entity which provides the annual external quality reviews shall not be a part of the state government, an MCO, or an association of any MCOs.

4. Recipient access to care will be monitored as part of each MCO's internal QIP and through the annual external quality review for MCOs. The periodic medical audits, state monitoring activities and the external quality review shall all derive the following information:

   a. Periodic comparisons of the number and types of Medicaid services before and after the institution of the MHC Program.

   b. Recipient satisfaction surveys managed by state staff.

   c. Periodic recipient surveys which the MCOs will conduct containing questions about recipient access to services.

   d. Measurement of waiting periods to obtain health care services; including standards for waiting time and monitor performance against these standards.

   e. Measurements of referral rates to specialists.

   f. Assessment of recipient knowledge about how to obtain health care services.

   g. Utilization and encounter data submitted by MCOs .

M. Access to Care

Iowa assures that recipients will have a choice between at least two MediPASS PMs or a combination of one MCO and the MediPASS program. When fewer than two choices are available in the geographic area, the managed care program is voluntary. In addition to this process, the MHC program is not likely to substantially impair access because of the following:

1. Recipients may choose any of the participating MCOs or MediPASS PMs in the service areas. In addition, as per 42 CFR 434.29, within an MCO each Medicaid enrollee has a choice of health professional to the extent possible and feasible.

2. The same range and amount of services that are available under the Medicaid fee-for-service program are available for enrollees covered under the MHC Program.

3. Access standards for distances and travel miles to obtain services for recipients under the MHC program have been established. Specifically, the MHC program must have a primary care provider within 30 miles or 30 minutes.

The Department utilizes the 30-mile/30-minute guideline for all MHC providers. This is applied to the MCOs at the time they request service to a new county, as well as quarterly thereafter. The Department requires the enrollment broker to review each county for PCP access on a quarterly basis in the MediPASS program. This report is submitted to the Department for review.

The Department realizes that there are rural portions of the state that simply do not have certain specialists within a 30-mile/30-minute radius. At the time of MCO expansion, the external quality review organization will review the specialist panel for adequacy. This is based on a knowledge of the existing pool of specialists and whether there are a sufficient number of specialists in the panel of the MCO to service the enrollment level of the area.

The MediPASS option allows the PCP to give a referral to any Iowa Medicaid provider, thus the panel of specialists would be the entire Iowa Medicaid provider network. This allows any MediPASS enrollee to see any specialist that accepts Iowa Medicaid. Therefore, this network is no less than the network available to a person not in the MHC program.

The Department realizes that there are some counties in the state that do not have a hospital. While the normal guideline is to have at least one hospital in the county being served, consideration is given to those counties without a hospital.

Additionally, if a county has multiple hospitals, the Department expects to see a fair representation on the provider network.

4. The number of providers to participate under the MHC program is expected to increase.

5. Primary care and health education are provided to enrollees by a chosen or assigned MCO or MediPASS PM. This fosters continuity of care and improved provider/patient relationships.

6. Pre-authorization is precluded for emergency care and family planning services under the MHC Program.

7. Recipients have the right to change plans at any time if good cause is shown.

8. MCOs and MediPASS PMs are required to provide or arrange for coverage 24 hours a day, 7 days a week.

9. Recipients have available a formal appeals process under 42 CFR Part 431, Subpart E. The same appeals hearing system in effect under the Medicaid fee-for-service program is in effect under the MHC program.

10. Iowa assures that state-determined access standards are maintained by quarterly analysis of provider panels.

11. Under the terms and conditions of their existing contracts, MCOs must:

    a. Assure that covered services are accessible to all enrollees, including those with limited English proficiency or reading skills, with diverse cultural and ethnic backgrounds, and with physical or mental disabilities.

    b. Provide to enrollees and prospective enrollees: an informational letter written in the applicable language explaining the MCO policies, a toll-free number to obtain further information about the MCO in the applicable language, all enrollment materials written in the applicable language, and translation services when necessary to ensure delivery of covered services.

    c. Inform a non-English-speaking enrollee about any provider who speaks the same non-English language, if the MCO is aware of any such provider.

12. Iowa has a limit (1,500) on the number of recipients that can be managed by a physician in the MHC program in effect under the MHC program. The limit guarantees access to appointments within acceptable time parameters for urgent and illness-related conditions as well as non-symptomatic preventive care. The number of Medicaid recipients also allows for the PM to serve a sufficient number of private-pay and commercially insured patients to create a mixture of patients reflective of the insurance status of the community may be required.

    The Department has designated a maximum limit for a MediPASS providers of 1,500 per provider. The Department allows an additional 300 enrollment for MediPASS providers with a physician assistant participating in the program. Contracted MCOs are expected to hold this requirement as part of the evaluation of provider panels for individual counties in which they are approved for participation.

    There has been one exception to this limit in regards to the FQHC in Polk County. As Polk County has over 15,000 Iowa Medicaid recipients eligible for the MHC program, this county has the largest concentration of enrollees in the state. The FQHC has satellite clinics that serve a large portion of the county. For these reasons, the Department has allowed the FQHC in Polk County to have a maximum enrollment limit of 2,500 enrollees. With the expansion of two MCO options into Polk County, the actual MediPASS enrollment to the FQHC has remained around 500 to 600 enrollees.